

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**BOULEVARD HEALTH CARE
PROGRAM, INC., IMPROPERLY
CLAIMED MEDICARE
REIMBURSEMENT FOR
OUTPATIENT PHYSICAL
THERAPY SERVICES**

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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Boulevard Health Care Program, Inc., improperly claimed at least \$56,000 in Medicare reimbursement for outpatient physical therapy services over a 2-year period.

WHY WE DID THIS REVIEW

Total Medicare Part B payments for outpatient therapy services have increased annually, with the rate of growth in payments exceeding the rate of growth in numbers of beneficiaries treated. In addition, prior Office of Inspector General reviews have identified claims for outpatient therapy services that were not reasonable, medically necessary, or properly documented, and vulnerable for fraud, waste, and abuse.

The objective of this review was to determine whether outpatient physical therapy services provided by Boulevard Health Care Program, Inc., (Boulevard) complied with Medicare requirements.

BACKGROUND

Federal regulations provide for the coverage of Medicare Part B outpatient physical therapy services. For outpatient physical therapy services to be covered, they must be medically reasonable and necessary, provided in accordance with a plan of care established by a physician or qualified therapist periodically reviewed by a physician, and certified by a physician. Medicare Part B also covers outpatient physical therapy services performed by or under the personal supervision of a therapist in private practice. Federal law precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

HOW WE CONDUCTED THIS REVIEW

Our review covered 3,901 claims for which Boulevard received Medicare reimbursement totaling \$213,863 for outpatient physical therapy services provided during the period January 1, 2011, through December 31, 2012. We reviewed a simple random sample of 100 of those claims.

WHAT WE FOUND

Boulevard claimed Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements. Of the 100 claims in our random sample, 57 complied with Medicare requirements, but 43 did not. Of these 43 claims, 2 contained more than 1 deficiency.

These deficiencies occurred because Boulevard did not have a thorough understanding of the Medicare reimbursement requirements related to claiming outpatient physical therapy services and did not have adequate policies and procedures in place to ensure that it billed services that met Medicare requirements.

On the basis of our sample results, we estimated that Boulevard improperly received at least \$56,664 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements, of which at least \$10,938 was within the 3-year claims recovery period.

WHAT WE RECOMMEND

We recommend that Boulevard:

- refund \$10,938 to the Federal Government for outpatient physical therapy services that did not comply with Medicare requirements and that are within the 3-year claims recovery period;
- work with the Medicare Administrative Contractor to return overpayments outside of the 3-year claims recovery period in accordance with the 60 day repayment rule;
- strengthen its policies and procedures to ensure that outpatient physical therapy services are provided and documented in accordance with Medicare requirements; and
- obtain a better understanding of Medicare requirements related to claiming outpatient physical therapy services, through such means as attending provider outreach and education seminars.

BOULEVARD HEALTH CARE PROGRAM, INC., COMMENTS

In written comments on our draft report, Boulevard did not indicate concurrence or nonconcurrence with our recommendations. However, it described actions it has taken so that its claims for outpatient physical therapy services comply with Medicare requirements.

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INTRODUCTION

WHY WE DID THIS REVIEW

Total Medicare Part B payments for outpatient therapy services have increased annually, with the rate of growth in payments exceeding the rate of growth in numbers of beneficiaries treated. In addition, prior Office of Inspector General reviews have identified claims for outpatient therapy services that were not reasonable, medically necessary, or properly documented, and vulnerable for fraud, waste, and abuse.

OBJECTIVE

The objective of this review was to determine whether outpatient physical therapy services provided by Boulevard Health Care Program, Inc., (Boulevard) complied with Medicare requirements.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part B provides supplementary medical insurance for medical and other health services, including outpatient physical therapy services. CMS contracts with Medicare contractors to process and pay Part B claims.

Medicare Outpatient Physical Therapy Services

Medicare Part B provides for the coverage of outpatient therapy services, including physical therapy.¹

Physical therapy services are designed to evaluate and treat disorders of the musculoskeletal system with the goal of improving mobility, relieving pain, and restoring maximal functional independence.

For Medicare Part B to cover outpatient physical therapy services, the services must be medically reasonable and necessary, provided in accordance with a plan of care (plan) established by a physician or qualified therapist, periodically reviewed by a physician, and certified by a physician.² Further, Medicare Part B pays for outpatient physical therapy services

¹ Sections 1832(a)(2)(C) and 1861(p) of the Act.

² Sections 1862(a)(1)(A) and 1835(a)(2)(C) of the Act.

performed by or under the personal supervision of a therapist in private practice.³ Finally, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.⁴

Medicare requirements are further clarified in chapter 15 of CMS's *Medicare Benefits Policy Manual* (Pub. No. 100-02) and in chapter 5 of its *Medicare Claims Processing Manual* (Pub. No. 100-04).

Boulevard Health Care Program, Inc.

Boulevard provides Medicare outpatient physical therapy services at its offices in Toa Baja, Puerto Rico. During the period January 2011 through December 2012, Boulevard's professional staff consisted of one physical therapist and four physical therapist assistants.

First Coast Service Options, Inc., serves as the Part B Medicare Administrative Contractor for providers in Jurisdiction N (formerly Jurisdiction 9), which includes Puerto Rico.

HOW WE CONDUCTED THIS REVIEW

Our review covered 3,901 claims for which Boulevard received Medicare reimbursement totaling \$213,863 for outpatient physical therapy services provided during the period January 1, 2011, through December 31, 2012 (audit period). We reviewed a simple random sample of 100 of those claims.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

Boulevard claimed Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements. Of the 100 claims in our random sample, 57 complied with Medicare requirements, but 43 did not. Specifically:

- For 37 claims, the plan did not meet Medicare requirements.
- For four claims, there were no treatment notes to support some of the services that Boulevard claimed Medicare reimbursement.

³ 42 CFR § 410.60.

⁴ Section 1833(e) of the Act.

- For two claims, there was no physician certification to support the services.
- For one claim, there was no progress report for the sample services.
- For one claim, Boulevard did not provide a medical record for the associated beneficiary.

Of these 43 claims, 2 contained more than 1 deficiency.

These deficiencies occurred because Boulevard did not have a thorough understanding of the Medicare reimbursement requirements related to claiming outpatient physical therapy services and did not have adequate policies and procedures in place to ensure that it billed services that met Medicare requirements. On the basis of our sample results, we estimated that Boulevard improperly received at least \$56,664 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements, of which at least \$10,938 was within the 3-year claims recovery period.^{5, 6}

PLAN DID NOT MEET MEDICARE REQUIREMENTS

Outpatient rehabilitation services must be provided in accordance with a written plan established before treatment begins. The plan must contain the type, amount, frequency, and duration of the outpatient physical therapy services to be furnished and must indicate the diagnosis and anticipated goals.⁷

For 37 claims, Boulevard received Medicare reimbursement for services that were not provided in accordance with a plan that met Medicare requirements. Specifically:

- For 31 claims, the plan did not include the amount, frequency, and duration of the services to be provided.
- For three claims, the plan did not include the type of service provided and billed to Medicare.

⁵ Our audit report represents the results for all claims within our audit period. Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, Boulevard is responsible for reporting and returning overpayments they identified to their Medicare administrative contractor. The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60 day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

⁶ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

⁷ 42 CFR § 410.61(c).

- For three claims, the plan did not include long-term goals.

NO TREATMENT NOTES

Medicare payments should not be made without the information necessary to determine the amount due the provider.⁸ In addition, a provider must furnish to its Medicare Administrative Contractor sufficient information to determine whether payment is due and the amount of payment.⁹

Therapists must maintain a treatment note for each treatment day and each physical therapy service. The treatment note must document the: (1) date of treatment, (2) identification of each specific service provided and billed, (3) total treatment time, and (4) signature and professional identification of the therapist who furnished or supervised the service.¹⁰

For four claims, Boulevard received Medicare reimbursement for services for which there was no treatment note. Specifically, for two of these claims, there was no treatment note to support any of the sample services and for the other two claims, there was no treatment note to support some of the sample services.

NO PHYSICIAN CERTIFICATION

Medicare may make payment for outpatient physical therapy services if a physician certifies: (i) that such services were required because the individual needed outpatient physical therapy, (ii) a plan for furnishing such services has been established by a physician or by a qualified therapist and periodically reviewed by a physician, and (iii) such services were furnished while the individual was under the care of a physician.¹¹ The provider must obtain the required certifications and keep them on file for verification if necessary.¹²

For two claims, Boulevard received Medicare reimbursement for services for which Boulevard did not provide a physician certification to support the need for outpatient physical therapy and that such services were furnished under the care of a physician.

NO PROGRESS REPORT

Progress reports provide the justification for the medical necessity of treatment. Medical necessity is determined based on the delivery of services as directed in the plan and as documented in the treatment notes and progress report. Progress reports must be prepared at least once every 10 treatment days or 30 calendar days, whichever is less. The first reporting

⁸ Section 1833(e) of the Act.

⁹ 42 CFR § 424.5(a)(6).

¹⁰ *Medicare Benefit Policy Manual*, chapter 15 § 220.3E.

¹¹ Section 1835(a)(2)(C) of the Act.

¹² 42 CFR §424.11(a)(1) and (2).

period begins the first day of the episode of treatment, regardless of whether the service provided on that day is an evaluation, re-evaluation, or treatment. The end of the progress report period is either a date chosen by the therapist, the 10th treatment day, or the 30th calendar day of the episode of treatment, whichever is shorter.¹³

For one claim, Boulevard received Medicare reimbursement for services for which a required progress report had not been prepared for the associated beneficiary. Specifically, no progress report was prepared before our sampled service (December 2, 2011) although treatment had begun 74 days earlier, on September 19, 2011.¹⁴

NO MEDICAL RECORD

Medicare payments should not be made without the information necessary to determine the amount due the provider.¹⁵ In addition, outpatient physical therapy services are payable when the medical record and information on the provider's claim form consistently and accurately report covered services. Medicare requires that the services billed be supported by documentation that justifies payment.¹⁶

For one claim, Boulevard did not provide a medical record for the associated beneficiary. Consequently, we had no assurance that Medicare requirements related to our sample outpatient physical therapy services were met.

CONCLUSION

On the basis of our sample results, we estimated that Boulevard improperly received at least \$56,664 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements, of which at least \$10,938 was within the 3-year claims recovery period.

RECOMMENDATIONS

We recommend that Boulevard:

- refund \$10,938 to the Federal Government for outpatient physical therapy services that did not comply with Medicare requirements and that are within the 3-year claims recovery period;

¹³ *Medicare Benefit Policy Manual*, chapter 15, § 220.3D.

¹⁴ A progress report was not prepared for the associated beneficiary until after their 20th treatment, on December 30, 2011, which was 103 calendar days after they began treatment.

¹⁵ Social Security Act §1833(e).

¹⁶ *Medicare Benefit Policy Manual*, chapter 15, § 220.3A.

- work with the Medicare Administrative Contractor to return overpayments outside of the 3-year claims recovery period in accordance with the 60 day repayment rule;
- strengthen its policies and procedures to ensure that outpatient physical therapy services are provided and documented in accordance with Medicare requirements;
and
- obtain a better understanding of Medicare requirements related to claiming outpatient physical therapy services, through such means as attending provider outreach and education seminars.

BOULEVARD HEALTH CARE PROGRAM, INC., COMMENTS

In written comments on our draft report, Boulevard did not indicate concurrence or nonconcurrence with our recommendations. However, it described actions it has taken so that its claims for outpatient physical therapy services comply with Medicare requirements. Boulevard's comments are included in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 3,901 Medicare outpatient physical therapy service claims, totaling \$213,863 that Boulevard provided during our audit period. These claims were extracted from CMS's National Claims History file.

We limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of Boulevard's policies and procedures for documenting and billing Medicare for outpatient physical therapy services. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted fieldwork at Boulevard's office in Toa Baja, Puerto Rico, from December 2013 through April 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations and guidelines;
- interviewed First Coast Service Options, Inc., officials to obtain an understanding of the Medicare requirements related to outpatient physical therapy services;
- met with Boulevard officials to gain an understanding of its policies and procedures related to providing and billing Medicare for outpatient physical therapy services;
- extracted from CMS's National Claims History file a sampling frame of 3,901 outpatient physical therapy service claims, totaling \$213,863, for the period January 1, 2011, through December 31, 2012;
- selected a simple random sample of 100 outpatient physical therapy service claims from the sampling frame;
- reviewed data from CMS's Common Working File and other available data for the sample claims to determine whether the claims had been cancelled or adjusted;
- obtained and reviewed case record documentation from Boulevard for each sample claim to determine whether the services were provided in accordance with Medicare requirements;
- estimated the total unallowable Medicare reimbursement paid in the sampling frame of 3,901 claims;

- estimated the unallowable Medicare reimbursement paid in the sampling frame of 3,901 claims that are within the 3-year recovery period; and
- discussed the results of our review with Boulevard officials.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all Medicare Part B outpatient physical therapy service claims paid to Boulevard for services provided during our audit period.

SAMPLING FRAME

The sampling frame was an Access database containing 3,901 outpatient physical therapy service claims, totaling \$213,863, provided by Boulevard during our audit period. The claims data was extracted from the CMS National Claims History file.

SAMPLE UNIT

The sample unit was an outpatient physical therapy service claim.

SAMPLE DESIGN

We used a simple random sample to review Medicare payments made to Boulevard for outpatient physical therapy services.

SAMPLE SIZE

We selected a sample of 100 outpatient physical therapy service claims.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in our sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We estimated (1) the total amount of inappropriate Medicare payments for unallowable outpatient physical therapy services during our audit period, and (2) the amount of overpayments for claims paid to Boulevard within the 3-year recovery period at the lower limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

TOTAL MEDICARE OVERPAYMENTS FOR THE AUDIT PERIOD

Sample Details and Results

Claims in Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Claims	Value of Unallowable Claims
3,901	\$213,863	100	\$5,646	43	\$ 1,854

Estimated Value of Unallowable Claims
(Limits calculated for a 90-Percent Confidence Interval)

Point Estimate	\$72,322
Lower Limit	\$56,664
Upper Limit	\$87,980

MEDICARE OVERPAYMENTS FOR CLAIMS PAID WITHIN THE 3-YEAR RECOVERY PERIOD

Sample Details and Results

Claims in Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Claims	Value of Unallowable Claims
3,901	\$213,863	100	\$5,646	12	\$533

Estimated Value of Unallowable Claims
(Limits calculated for a 90-Percent Confidence Interval)

Point Estimate	\$20,779
Lower Limit	\$10,938
Upper Limit	\$30,621

APPENDIX D: BOULEVARD HEALTH CARE PROGRAM, INC., COMMENTS

Boulevard Health Care Program

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August 27, 2015

Report Number: A-02-14-0100y

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Regional Inspector General

For audit services

According with the recommendations made in the report the followings actions were taken by Boulevard Health Care Program to comply with the medicare requirement. The new templates to be used in evaluation and reevaluation are going to include parts for the documentations including number of therapy sessions, frequency of therapies, duration, time of each specific modality. Reevaluation after ten therapies will be done. Also the sheet of optimal Instrument used by American Physical Therapy Association will be used too.